

Vermont State Hospital Policy		B9
Emergency Involuntary Procedure Policy		<u>INTERIM 033009</u>
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Advanced by Vermont State Hospital Policy Committee:		Date:
Approved by Governing Body of Vermont State Hospital:		Date: 11-16-2006

### Policy Statement:

Patients at VSH have the right to make informed choices concerning their modes of treatment. A person in VSH who has not been found by a court to be a person in need of treatment or a person in need of further treatment and committed to VSH shall not be treated involuntarily in a non-emergency situation. Non-emergency treatment can only be provided if the patient has given his or her consent without pressure or coercion, unless so ordered by a court. Emergency involuntary procedures can only be used in emergency situations.

Staff at the VSH continually explore ways to prevent, reduce, and strive to eliminate restraint, seclusion, and emergency involuntary medications through education, training, and effective performance improvement initiatives.

VSH is committed to establishing and maintaining a treatment environment that is safe, clinically effective, and non-violent. VSH staff are trained in non-physical, non-coercive skills and attitudes that emphasize the prevention of emergencies whenever possible.

Emergency involuntary procedures at VSH are used as safety measures of last resort, with the intention of preventing or minimizing violence, in a manner consistent with the principles of recovery, and with respect for the impact of trauma in the lives of many hospitalized individuals.

VSH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with generally accepted professional standards of care.

The only basis for emergency involuntary administration of medication, seclusion, or restraints is in the legitimate exercise of the State's authority to control an emergency and prevent serious bodily harm to patients and/or others. When necessary, these measures shall be utilized in the least intrusive and restrictive manner and for the least amount of time consistent with the need to protect the patient and others consistent with good medical practice. When emergency involuntary procedures must be used, VSH staff shall respect and protect each patient's dignity.

These measures shall not be unnecessarily used in combination. All VSH Staff members implementing involuntary procedures requiring physical interventions shall be trained and have ongoing education and training in the proper and safe use of restraints to ensure the safety of patients and staff and shall have successfully completed competency-based training regarding implementation of all such policies and the use of less restrictive interventions. This training shall also raise staff awareness about how emergency involuntary procedures may be experienced by the patient.

Seclusion or restraint shall terminate at such time as the patient's behavior no longer poses an imminent threat of serious bodily harm to the patient or others. Where possible, written documentation of the use of these measures shall occur prior to their implementation. Staff shall abide by the following policies and procedures.

**Purpose:**

- I.** To ensure that emergency involuntary procedures are used only in emergency situations.
- II.** To ensure that VSH complies with rules set forth in the Doe vs. Miller settlement, as amended by this policy.
- III.** To ensure that VSH complies with CMS Condition of Participation; Patients' Rights, 42 CFR 482.13(f).
- IV.** To protect and promote each patient's rights.

**Procedures:**

The below procedures shall only be applied in an emergency, which is defined as:

- A significant change in the patient's condition or past behavior;
- Resulting in the imminent threat of serious bodily harm to the patient or others;
- So that some action is immediately necessary to protect the patient or others; and it is impracticable to first obtain consent.

Restraints and seclusion shall only be used in a reliably documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted.

Restraints and seclusion shall not be used in the absence of, or as an alternative to, active treatment. Restraints and seclusion shall not be used as punishment or for the convenience of staff.

Restraints and seclusion shall not be used as part of a behavioral intervention.

**I. Emergency Involuntary Medication**

Emergency involuntary psychotropic medication shall be used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress.

A drug used in emergency circumstances is used as a restraint to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

Some patients seriously object to taking psychotropic medication. Many patients are particularly concerned about the adverse effects of such medication, such as permanent muscular disorders, diminished spontaneity, blurred vision, palpitations, diarrhea or constipation, low blood pressure and fatigue. Consequently, the patient and staff must weigh the possible benefits against the risks of treatment with psychotropic medication.

As used in this policy for emergency involuntary medication, a "standard treatment" for a medication used to address a patient's medical or psychiatric condition would include all of the following:

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- The medication is used within the pharmaceutical parameters approved for it by the Food and Drug Administration and the manufacturer, for the indications it is manufactured and labeled to address; and
- The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization; and
- The use of the medication to treat a specific patient's clinical condition is based on that patient's target symptoms, overall clinical situation, and that patient's expected and actual response to the medication.
- An additional component of "standard treatment" for a medication is the expectation that the standard use of a psychotherapeutic medication to treat the patient's condition enables the patient to more effectively or appropriately function in the world around him or her than would be possible without the use of the medication. Psychotherapeutic medications are to enable, not disable. If a psychotherapeutic medication reduces the patient's ability to effectively or appropriately interact with the world around him/her, then the psychotherapeutic medication is not being used as a "standard treatment" for the patient's condition.

No individual who has not been found by a court to be subject to an order for non-emergency involuntary medication pursuant to 18 VSA §7627 shall be involuntarily medicated except in an emergency. If involuntary medication has been ordered as a result of a finding that an emergency exists, the patient shall be offered oral medication, but may be given an injection if oral medication is declined or is impossible to administer. When it becomes necessary to administer involuntary medication by injection in emergency situations, a non-depot medication that is consistent with current American Psychiatric Association practice guidelines will be used. Depot medications shall not be used to involuntarily medicate any person unless pursuant to an order for non-emergency involuntary medication pursuant to 18 VSA §7627. All phases of an involuntary medication procedure shall be properly documented.

- A. If, on the basis of personal observation, any VSH staff member believes an emergency exists with respect to a patient, a physician shall be consulted immediately.
- B. The physician shall personally examine the patient.
- C. The physician shall determine whether such facts exist with regard to the patient which necessitates his/her emergency involuntary medication. (The required facts are specified in the "Certificate of Need" form (PN-04-05).
- D. If, after personal observation of the patient, and only if emergency medication is found to be necessary, the physician may order the involuntary administration of medication, as set forth in I, above. Orders for emergency medication shall not be written as a PRN, [telephone](#) or standing order.
- E. A physician shall assess the patient within one hour of the administration of the emergency involuntary psychotropic medication.
- F. A physician shall report the emergency involuntary medication of the patient to the Medical Director or physician designated to receive such reports on weekends or holidays, within twenty-four (24) hours.
- G. Whenever three [episodes](#) of emergency involuntary psychotropic medication occur within a four-week period, the patient's treatment team shall, within three business days, conduct a review of the individual's treatment plan, and, in a clinically-justifiable manner determine whether to modify the patient's treatment plan, and implement any revised plan, as appropriate.
- H. With the patient's consent, the nearest relative or guardian of the patient shall be notified of emergency involuntary administration of medication within twenty-four (24) hours of its first

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By the end of twenty-four (24) hours, the Medical Director or physician designated to receive such reports on weekends or holidays shall see and assess the patient to determine whether the emergency continues to exist and the need for continuing emergency medication. If the medical record and Certificate of Need (PN-04-05) do not adequately document the necessity for medication or if alternative, less intrusive modes of control have not been carefully considered or attempted, the Medical Director shall disapprove continuing the administration of involuntary emergency medication, unless he/she has made a personal and independent clinical determination consistent with paragraphs A through E of this section. If the emergency continues for more than twenty-four (24) hours, an independent review by the Medical Director shall occur within the next twenty-four (24) hours. The Medical Director shall review the situation on each working day thereafter until the emergency ceases to exist.

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use. Counsel shall be notified and provided with a copy of the Certificate of Need (PN-04-05) within twenty-four (24) hours.

## II. Emergency Seclusion

Secluding a patient is a valid procedure that may be used only in an emergency situation. Seclusion can only be used if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective. Seclusion, properly used, can provide containment, isolation, and decreased sensory input for the patient with such needs. Its usefulness in reducing symptoms in the drug-refusing patient may be especially important.

Placement of a patient in seclusion and the duration of its use shall be kept to a minimum, consistent with the safe and effective care of patients and shall adequately accommodate a patient's physical and environmental needs without undue violation of his/her personal dignity. No order for seclusion shall extend beyond a two (2) hour period for adults or a two (2) hour period for patients 17 and younger. The patient shall be constantly observed. Observations of the patient shall be documented every fifteen (15) minutes by staff persons who have successfully completed competency-based training on the monitoring of persons in seclusion.

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All phases of seclusion of a patient shall be implemented in the least restrictive manner possible and properly documented.

- A. The seclusion of a patient may be ordered only after personal observation of emergency circumstances by a physician, or in the physician's absence, a registered nurse (RN). Within one hour of the initiation of the safety intervention, individuals placed in seclusion shall be assessed by a physician or licensed medical professional trained in the use of emergency safety interventions. This assessment must occur face to face and shall include but not be limited to an assessment of: (1) the individual's physical and psychological status; (2) the individual's behavior; (3) the appropriateness of the intervention measures; and (4) any complications resulting from the intervention.
- B. The patient shall be constantly observed by a staff member who has successfully completed competency based training on the monitoring of persons in seclusion. Observations of the patient shall be documented every 15 minutes.
- C. A Certificate of Need (PN-04-05) for emergency seclusion shall be entered in the patient's record that documents emergency circumstances requiring the use of seclusion and that less restrictive measures have been considered and determined to be ineffective to protect the patient and others. Orders for seclusion shall not be written as PRN, telephone or standing orders.
- D. Seclusion shall be terminated as soon as the individual is no longer an imminent danger to himself/herself or others.
- E. At the earliest possible time, and within one (1) hour, the physician shall either order the patient out of seclusion or certify the need for continuing an emergency seclusion beyond that point of time. Orders for seclusion shall not be written as a PRN or standing order.
- F. For adults, the physician may authorize additional seclusion up to two (2) hours which may be administered consecutively without consultation with the physician, but only after the registered nurse (RN) reviews and documents the continuing emergency necessity for an additional time period. No more than two (2) consecutive seclusions, or four (4) hours in total, may be ordered without consultation with and personal observation by the physician
- G. At least hourly, a registered nurse (RN) must assess the continued need for the emergency seclusion intervention and document assessment and ongoing need for the intervention.

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- H. On the next working day following an order of seclusion, the Medical Director or his/her designee shall review any orders for seclusion of the patient. If a patient is secluded for more than ten (10) hours in any twenty-four (24) hour period, or for more than twenty-four (24) hours in any five (5) day period, the staff shall report the case at the next patient-oriented meeting and submit a written report to the Medical Director, ~~and the Commissioner of Mental Health, both of~~ whom shall review the Certificate of Need (PN-04-05) and other documentation for adequacy.
- I. For any patient placed in seclusion more than three times in any four-week period, the patient's treatment team shall, within three business days, review , and modify as appropriate, the individual's treatment plan.
- J. With the patient's consent, the nearest relative or guardian of the patient shall be notified of emergency involuntary administration of seclusion within twenty-four (24) hours of its first use. Counsel shall be notified and provided with a copy of the Certificate of Need (PN-04-05) within twenty-four (24) hours.

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### III. Emergency Physical And Mechanical Restraints

Restraint is the direct application of physical force to a patient, with or without the patient's permission, to restrict his/her freedom of movement. A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he/she cannot easily remove that restricts movement or normal access to one's body. Holding a patient and restricting movement constitutes restraining him/her.

Involuntary placement of a patient in restraints is a valid procedure that may be used only in emergency circumstances and in the least restrictive manner. Any use of mechanical restraints at VSH shall be in conformity with 18 V.S.A. §7704, which reads:

"Mechanical restraints shall not be applied to a patient unless it is determined by the head of the hospital or his designee to be required by the medical needs of the patient or the hospital. Every use of a mechanical restraint and the reasons, therefore, shall be made a part of the clinical record of the patient under the signature of the head of the hospital or his designee."

The use of restraints shall be kept to a minimum consistent with the safe and effective care of patients. No order for the use of restraints shall extend beyond a two (2) hour period for adults or a two (2) hour period for patients 17 and younger. Restraints shall be terminated as soon as the individual is no longer an imminent danger to himself/herself or others, unless otherwise clinically indicated. The patient shall be constantly observed. The patient shall be assessed every fifteen (15) minutes by staff persons who have successfully completed competency-based training on the monitoring of restraints.

Restraints are to be applied in the least restrictive manner, providing for padding and protection of all parts of the body where pressure areas might occur by friction from mechanical restraints; be ended at the earliest possible time, and shall:

1. Be adjusted to eliminate the danger of gangrene, sores and paralysis;
2. Allow room for healthy breathing; and
3. Allow the patient as much freedom as possible under the circumstances.

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Patients in restraints shall be encouraged to take liquids, be allowed reasonable opportunity for toileting, and shall be provided appropriate food, lighting, ventilation and clothing or covering.

VSH prohibits the use of mechanical restraints in a prone position. The following types of

restraints are acceptable for use during psychiatric emergencies:

- 4-point restraint (patient's wrists and ankles are secured to a bed).
- 5-point restraint (as above, with the addition of a chest strap, also secured to the bed).
- Belt and wristlets (patient's wrists are secured to a waist belt).
- Posey vest (patient wears a vest which can be secured to a chair or a bed; patient's arms remain free).
- Use of physical force to control a patient who is resisting the administration of involuntary psychotropic medication.

- A. The involuntary restraint of a patient by any means may be ordered only after personal observation of emergency circumstances by a physician; or in the physician's absence, a registered nurse (RN). Within one hour of the initiation of the emergency safety intervention, individuals placed in restraint shall be assessed by a physician. This assessment must occur face to face and shall include but not be limited to an assessment of: (1) the individual's physical and psychological status; (2) the individual's behavior; (3) the appropriateness of the intervention measures; and (4) any complications resulting from the intervention.
- B. A Certificate of Need (PN-04-05) for emergency restraint shall be entered in the patient's record that documents emergency circumstances requiring the use of restraints and that less restrictive measures have been considered and determined ineffective to protect the patient and others. Orders for restraint shall not be written as a PRN, telephone or standing order.
- C. The patient shall be constantly observed by a staff member who has successfully completed competency based training on the monitoring of persons in restraint. Observations of the patient shall be documented every 15 minutes.
- D. The physician shall order at the earliest possible time either the patient out of restraints or enter the need for continuing an emergency restraint beyond that point in time.
- E. For adults, the physician may authorize additional restraints up to two (2) hours which may be administered consecutively without consultation with the physician, but only after the registered nurse (RN) reviews and documents the continuing emergency necessity for an additional time period. No more than two (2) consecutive restraints, or four (4) hours in total, may be ordered without consultation with and personal observation by the physician. Each twenty-four (24) hour period and with continuation of an emergency condition, the physician must see and assess the patient before issuing new written orders for emergency restraint.
- F. At least hourly, a registered nurse (RN) must assess the continued need for the emergency restraint intervention and document assessment and ongoing need for the intervention.
- G. On the next working day following an order of restraint, the Medical Director or his/her designee shall review any orders for restraint of the patient. If a patient is restrained for more than ten (10) hours in any twenty-four (24) hour period or for more than twenty-four (24) hours in any five (5) day period, the staff shall report the case at the next patient-oriented meeting and submit a written report to the Medical Director, and the Commissioner of Mental Health, both of whom shall review the Certificate of Need (PN-04-05) and other documentation for adequacy.
- H. For any patient placed in restraints more than three times in any four-week period, the patient's treatment team shall, within three business days, review, and modify as appropriate, the individual's treatment plan.
- I. With the patient's consent, the nearest relative or guardian of the patient shall be notified of emergency involuntary administration of restraint within twenty-four (24) hours of its first use. Counsel shall be notified and provided with a copy of the Certificate of Need (PN-04-05) within twenty-four (24) hours.

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#### IV. Medical Director Review

The Medical Director shall review all orders of emergency involuntary medication, seclusion and restraint at least once every thirty (30) days and shall prepare a report to the Commissioner of Mental Health, the Executive Director and the Treatment Review Panel.

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#### Definitions:

1. **"Consent"** - The agreement by an individual to undergo a particular course of treatment after receiving an explanation of and demonstrating an understanding of the nature of a proposed course of treatment, including the potential risks and benefits of that particular form of treatment. An individual must have the capacity to give consent, i.e., he/she has the mental ability to make decisions concerning medical treatment or other basic decisions with respect to managing his/her own personal care.

2. **"Depot Medication"** - Chemical forms of certain anti-psychotic medication which allow the active medication to be released over an extended time frame. These medications are injected intra-muscularly and need only be administered every two (2) to four (4) weeks.

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3. **"Designated Physician"** - A physician not on the regular staff of VSH who has professional training, experience, and demonstrated competence in the treatment of mental illness and who is designated by the Commissioner.

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4. **"Documentation"** - The factual basis for all opinions on the prescribed forms and in other records, which must be explicit, descriptive, and not conclusory. The test of adequacy of documentation is whether an independent qualified mental health professional could readily verify from such documentation the factual basis for and the medical necessity of the prescribed action, as well as its involuntary administration. The elements of adequacy shall enable the reviewer to determine:

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- a. The necessity for the action taken to control the emergency;
- b. The expected or desired result of the action on the patient's behavior or condition;
- c. Whether the action is an accepted medical practice or is experimental;
- d. Whether less intrusive actions were considered;
- e. The risks of adverse side effects; and
- f. The extent of bodily intrusion, pain, or discomfort.

5. **"Emergency"** - A significant change in the patient's condition or past behavior resulting in the imminent threat of serious bodily harm to the patient or others, so that some action is immediately necessary to protect the patient or others, and it is impracticable to first obtain consent.

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6. **"Head of Hospital"** - a.k.a. VSH Executive Director of VSH, or persons in charge at anytime. See 18 V.S.A. §7101(6).

7. **"Involuntary Medication"** - The administration of any medication against a patient's will.

**Deleted: Impracticable** - Impossible to do or carry out.

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8. **"Involuntary Patient"** - A person present at VSH who has been found by a court to be a person in need of treatment or a patient in need of further treatment to the statutory definitions found in 18 V.S.A. §7101 (16) and (17).

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9. **"Restraint"** - Restraint is the direct application of physical force to a patient, with or without the patient's permission, to restrict his/her freedom of movement. A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he/she cannot easily remove that restricts movement or normal access to one's body. Holding a patient and restricting movement constitutes restraining him/her.

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10.	"Medical Director" - (a.k.a. Chief of Clinical Services) A psychiatrist responsible for supervision of the care and treatment of all patients at VSH.	Formatted: Bullets and Numbering
11.	"Physician" - A licensed physician on the staff of VSH.	Deleted: ¶ <#>"Nurse" - A licensed, registered nurse on the staff of VSH.¶
12.	"Psychologist" - A licensed psychologist on the staff of VSH.	Formatted: Bullets and Numbering Formatted: Bullets and Numbering
13.	<del>"Qualified Mental Health Professional" - A psychiatrist, physician, psychologist, social worker, nurse or area/unit supervisor who by training and experience can identify mental illness and recognize behavior which would constitute an emergency.</del>	Formatted: Bullets and Numbering
14.	<del>"Regular Working Hours" - The usual daytime working hours of VSH; 8:00am to 4:00pm.</del>	Formatted: Bullets and Numbering
15.	"Seclusion" - The involuntary confinement of a person in a room or area where the person is prevented from leaving.	Deleted: <#>"Qualified Mental Health Professional" - A psychiatrist, physician, psychologist, social worker, nurse or area/unit supervisor who by training and experience can identify mental illness and recognize behavior which would constitute an emergency.¶ <#>"Regular Working Hours" - The usual daytime working hours of VSH; 8:00am to 4:00pm.¶
16.	"Staff" - Nurses, physicians, psychologists, social workers, and psychiatric technicians who are employed by VSH to provide care and treatment for patients.	Formatted: Bullets and Numbering
17.	"Treatment Review Panel" - A panel appointed by the Commissioner of Health consisting of at least three persons who are interested and knowledgeable in the areas of emergency procedures, none of whom are part of the workforce of VSH.	Deleted: , psychiatrists Deleted: area/unit supervisors,